Good afternoon and thank you for this opportunity. My name is Dave Killips and I am the superintendent of the Chelsea School District.

I am here today to share some facts and our story on our struggle to continue to offer quality programming.

First, I need to take a minute and give you a little background on Chelsea. Chelsea is a high performing district that sends approximately **80%** of its graduates to college. We are a district that offers an excellent education to all students, not only in the classroom, but in extra-curriculars as well. This past year **95%** of our students who took almost **400** Advanced Placement tests passed – an extremely high percentage.

The community has historically supported of our schools. In **2004** the community passed a bond issue and an ISD-wide special education millage; in **2006** they passed a Sinking Fund; and in **2009** they passed another bond issue. Much of the focus during these various campaigns was to maintain our General Fund for the classroom and to move appropriate expenses to the bond, sinking and special education budgets. In fact, with a unique approach to the last bond approval, we will be able to purchase our buses and technology for essentially the next decade, which, in turn, will keep those expenses out of our General Fund.

We are a district, like most districts, that continues to struggle financially. We have been drawing upon our reserves to balance our budget in order to continue to offer the quality of education our community expects and deserves. This is the first time in many, many years that we are beginning a school year with teachers on lay-off.

With that as background information I would like to focus on our present situation and how the insurance program makes an impact. We have been hit by unusually high insurance premium increases over the last several years. This is after we have switched from a Traditional Blue Cross program to a PPO Blue Cross Program and then to a Health Reimbursement Account (HRA) program. We are not a MESSA district.

In the **2002** school year we went from the Traditional Blue Cross program to a PPO offered by Blue Cross. In comparing full-family insurance rates, we reduced our premium from **$8,913** per year to **$7,446** per year – a **20%** savings. In **2006** we shifted from the PPO program to the Blue Cross high-deductible HRA program. This change reduced our rates from **$13,299** in **2006** to **$10,447** per year. This equates to a savings of **27%** on premiums. The Chelsea School District has saved over **$250,000** per year in premiums, plus has recouped all unused deductibles by moving to the HRA from the PPO.

In **2006** when we moved to the current HRA plan we also compared rates with local MESSA districts. Our annual premiums were about **$2,400** less. Our changes in programs came after consultation with Blue Cross, industry experts and negotiating with our local association. We have always offered our employees a quality health care program.

However, in **2008** we had a **23%** increase in our premiums for the HRA; plus over a **29%** increase for this school year. These increases alone equate to over **$325** per student. This is money that is directly taken out of programming. At the same time, from **2002** until the **2008** school year, we have experienced an average of a **1.5%** increase in the Student Foundation Allowance and an **11%** decrease in enrollment. This is not subtracting the decrease we will most likely see in the Foundation Allowance and

catagoricals this year. With these significant rate increases I can only conclude that Blue Cross does not wish to offer this type of plan in the future as it is becoming cost prohibitive. On top of these rate increases, this spring Blue Cross attempted to add a surcharge of up to **32%** on the premiums for high deductible plans, like the HRA we offer. Fortunately they were not successful. If they had been successful our premiums for their product would have increased over **61%** in one year or in excess of **$250** per student.

I am starting my eighth year with the Chelsea School District. For a beginning teacher, who began when I did, and earned a Master's Degree which most of them do, the employment costs for that teacher have increased 115%. During that timeframe retirement costs have increased **186%** and insurance premiums have increased **121%**. Retirement and insurance costs are driving dollars out of the classroom and ultimately reducing the programs and educational opportunities we offer our students.

If you take a look at a veteran teacher, at the top of the scale, employment costs, over that same time period, have increase **32%**. Of those costs, retirement costs have increased by **63%** while insurance premiums have increased the same **121%**. Again, these insurance increases have taken place even though we switched from a Traditional insurance program to a PPO to a HRA – all of which industry leaders, consultants and Blue Cross indicated were cost saving measures for our District. In other words, we are being very diligent with our funds but continue to struggle.

If we hired a new teacher today our insurance costs would drive up the cost of employment by **44%**. Insurance and retirement combined would drive it up by **61%.**

I am not suggesting our employees, who have received between a **2%** and **3%** increase each year are not deserving – they are. We certainly are

not the highest paying district within our ISD. My concern is that retirement and insurance costs continue to force cuts to teachers, custodians, secretaries, bus drivers, administrators and other support staff. Class sizes have increased, field trips have been cut, athletic budget trimmed, fewer dollars are being allocated to curriculum, professional development has been reduced and community education cut significantly – all of which decreases the quality of programming we offer our children. We have consolidated and contracted services with other districts, our ISD, private companies and local municipalities for years in an effort to control our costs while maintaining our educational quality. Cuts have been on-going in our district since **2002** with no end in sight.

I would implore each and every one of you to consider all avenues that will enable local school districts to maintain as many educational dollars as possible in the classroom to educate the children of this state while maintaining a quality, but affordable, health care program for our employees. The idea of state-wide health care pooling that incorporates a hard cap on insurance costs for districts; and includes a wellness or prevention based component deserves your attention and your action. A healthy workforce is essential to maintaining a quality work force, who, in turn, can offer our children a quality education. After all, I believe there is no better investment we can make than investing in our children and their future.

Thank you for your time and allowing me to share a local school district's story.

TESTIMONY BEFORE
PUBLIC EMPLOYEE HEALTH CARE REFORM COMMITTEE
SEPTEMBER 10, 2009

by: Phillip L. Thompson, SEIU

Madam Chair & Committee Members:

I would like to express my appreciation to you for giving me the opportunity to make a few comments before the Committee this afternoon.

My name is Phil Thompson and I appear before you as President of the SEIU *(Service Employees International Union)* State Council which collectively represents approximately 80,000 employees here in Michigan, including about 14,000 classified state employees and another 6,000 school, county and municipal employees. In addition, I am also honored to be an International Vice President with SEIU.

As you may, or may not know, the Service Employees International Union is the largest union representing health care workers, including doctors, nurses, hospital aides, nursing home and home care workers, in the United States. In addition, SEIU is the second largest union of public employees, with over one million members throughout the United States, Canada and Puerto Rico.

The convergence of health care issues with potential impact on public employees and employers, is of primary importance to our membership.

As I understand the charge of this Committee, you have been asked to review issues, involving potential cost savings and efficiencies in Michigan public employee health plans.

It appears that the initiative to jump start this Committee's activity was the concept of "pooling" all public employees in Michigan - the so called "Dillon Plan" that was released in general concept in July. I want to say at the onset that SEIU has worked with

Speaker Dillon on several issues and projects in the past and all of us at SEIU have great respect for his leadership, insightfulness, and his ability to approach issues in an innovative manner. We simply disagree on this approach.

Having said that, we respectfully believe that this most recent proposal to massively overhaul the state of Michigan's public health plans is an overly simplified and overly optimistic approach to developing health care reform or any meaningful savings. In addition, the unintended consequence of this proposal is a direct assault on the ability for workers to have a meaningful voice in the development and cost of their health plans.

I have reviewed the sixteen page "Summary" several times to try to understand exactly what Speaker Dillon's proposal is trying to accomplish – and the process for meeting these projected goals.

There are three basic concepts to the Dillon Proposal:

1. Establish a large "pool" to cover all of Michigan's public employees health insurance;
2. Establish a Board or Committee to work with the Office of the State Employer (OSE) to Officially develop a very limited number of health plan options for public employees to choose from;
3. Generate an estimated $600-900 million per year savings through a combination of administrative efficiencies and benefit standardization – which all of labor views as a code phrase for benefit reductions.

The underlying assumption seems to be that public employee health benefits are just too costly when compared to comparable employment settings in other state public plans as well as within the private sector.

However, two fairly recent reports issued to the Michigan Legislature – the 2007 House Fiscal study and the 2009 Professor Charles Ballard study - seem to refute this

assumption. [Ballard Study attached].

Even if, at some time in the past, the State Employee Health Plans were on the high side of the cost equation, many of these differences have been successfully addressed on numerous occasions through the collective bargaining process between the state employee unions and the Office of the State Employer. [Exhibit 1].

[Matrix Award Story - 1993]
[Carve O— RX; Foot; Mental Health; Chronic Disease]

However, there continues to be very rational reasons why some of the state employee plans still seem more costly than other statewide plans. I believe Phil Powers identified comparisons to some selected states but quickly pointed out that no in-depth analysis had been done in his report.

I believe a large portion of these higher costs can be attributed to the following:

a) dumping of health care costs on to the state plans (examples);
b) original 10-year vesting schedules which have long ago been converted to 30 year schedules (3% per year);
c) an aging workforce which, by definition, incurs higher health coverage costs. There has been very little hiring in recent years to help balance out the average age in state employment.

All three of these cost drivers have either already been remedied in some manner or are simply well beyond the scope of any "pooling" concept.

The plain fact is that virtually all Michigan public employees with health coverage are already in sizeable pools - examples being the AFL Public Employee Trust; MESSA; and large Blue Cross Group Plans. There is serious reservations that there are any additional economies to scale when a group gets beyond ten to twenty thousand covered lives, and some studies set this level as low as 2,000 - 5,000.

There simply isn't any additional "squeeze" for savings by collapsing existing large, cost effective group plans into one **super pool**.

One additional point bears mentioning as it pertains specifically to state employees in Michigan. The Michigan Constitution, Article XI gives what is often referred to as "plenary" authority for all compensation and benefit levels to the Michigan Civil Service Commission - a bi-partisan Commission established in the 30's, reinforced in the 40's, and reiterated in the 1963 Constitution with the sole constitutional authority for establishing wages, benefits and conditions of employment for state employees. [Emphasis added]. The Michigan Legislature may not have the legal authority to unilaterally pool over 50,000 state employees into a huge public employee group. [Exhibit 2].

My final comments deal with any projected savings from the administrative efficiencies generated by removing the responsibilities for plan development and collective bargaining from local municipal, township, county, and school board officials. The simple fact is that virtually all of these administrative positions will still be needed, and heavily relied upon to negotiate and administer the balance of all the benefit plans and bargaining agreements. No serious proposal would suggest that most, if not all, of these positions could be eliminated just because health plans were removed from local officials.

The collective bargaining process at the local level best fosters cost savings, innovative ideas, and the development of plans that meet the needs, priorities and desires of that local group.

The priorities and cost-sharing ideas for a group of school lunch aides in Niles is much different than those of a hundred school bus drivers in Flint, or DPW workers in Royal Oak.

No state level super-group will be able to judge the pulse or priorities of hundreds of small, or large communities across this great state and force feed them in to five or six

huge pool plans. It just doesn't work.

All efforts should be made to continue to allow workers at the local level to have a real voice in determining their health plans. This is best done through the collective bargaining process. Equal voices - mutual respect - and a sense of local priorities.

So far I have commented on what SEIU considers very serious short comings, and in some cases mis-representations of what this pooling proposal accomplishes.

It is important for all of us to focus on the real culprits driving double-digit cost escalation of all of our health plans:

a. Excessive and duplicative medical procedure costs
b. The impact of almost fifty million uninsured or seriously under-insured people in this country
c. The built-in incentives in medical service and procedural costs instead of focusing on prevention and wellness goals;
d. the explosion of drug costs.

Michigan will not, and cannot, address these issues in a vacuum. They must be addressed at the National level. This gut wrenching process is now happening at this historic time in Washington DC – as it should be.

The Michigan Legislature should hold off any massive overhaul of any health plans – public or private – until we understand the full impact resulting from National Health Care Reform. All parties to this debate want reform. The President has said that there appears to be agreement on eighty percent of a national reform package. The goal is a comprehensive, cost-savings plan yet this Fall.

Thank you, again, for allowing me this opportunity to address this Committee.

EXHIBIT 1

STATE EMPLOYEE'S HEALTH CARE COST

1997-1998: Health care premiums were suspended for 10 pay periods to restore balance in collection (December 28, 1997 thru January 10, 1998). No co-payment required for maintenance drugs thru Caremark mail order. Retail co-payments $7 brand and $2 generic drugs. Some HMO's had premiums and no co-payments for drugs

1998-1999: State Health Plan Advantage premiums increased 8%. No change in dental, vision, life, ltd. HMO's started to collect premiums. Major medical increased from 100/150 per member and 200/300per family. Annual out of pocket increased 750/1000 per member per calendar year. Prescription drugs remain retail $7 brand and $2 generic. Merck-Medco has mail order an no co-payment required for 90 day supply. Some HMO's had premiums and no co-payment for drugs.

1999-2000: State Health Plan Advantage premiums increased 8% Major medical remained the same until January 1, 2000. Major medical increased from 150/300 per member and 300/600 per family. Maximum out of pocket remained at $1000. Prescription drugs co-payment increased to $10 brand and $5 generic for both retail and mail order. Some HMO's had premiums and a $2 co-payment for drugs was initiated. Dental increased 15% in premiums.

2000-2001: State Health Plan Advantage premiums increased 15%. Deductibles and Co-pays remain unchanged. Dental premiums increased 20%. Vision premiums increased 10%. Prescription drugs continue at $10 brand and $5 generic. Life insurance (employer paid) increased.

2001-2002: State Health Plan Advantage premium increased 8%. No change in dental, vision, ltd, or prescriptions. HMO's premiums increased 5%-32.7% depending on residential location. This put employees at a 6%-12.2% deficit depending on whether they had the SHP or HMO.

2002-2003: Restructured State Health Plan from the Advantage to PPO. We now have a $10.00 office visit co-pay and $50 emergency room co-pay. Preventative Services covered 100% up to $500 per person. Deductibles changed to 200 individual/400 family max in network, 500 individual/1000 family max out of network. No change in premiums for SHP, dental and vision. Prescription increased to $12 brand and $7 generic. Dental annual maximum increased to $1250. Ltd increased maximum benefit to $5000/month. HMO's increased 5.5% with $10 office visit, $50 ER co-pay. Prescription drugs increased $10 brand and $5 generic.

2003-2004: State Health Plan-PPO premiums increased 20%, Dental premiums increased 12%, with yearly maximum increased to $1500. Preventative services increased to $750 per person per year. Deductibles for SHP-PPO remain unchanged. Prescription drugs increased $15 brand and $7 generic. No change in vision and Ltd. HMO's premium increase 15%, with no change in prescription drug co-pays.

2004-2005: State Health Plan-PPO premium increased 6%. No change in Prescription coverage until October 1, 2005 when mandatory Mail Order for Maintenance Drugs. No change in Vision and LTD. Dental premiums reduced. Blue Health Connection and Durable Medical Equipment Network started October 1, 2005.

2005-2006: State Health Plan-PPO premium increased 24%, Dental increased 15%, Vision increased 6% and LTD premium decreased 4.5% (except for UAW). No change in Deductibles and Co-pays.

2006-2007: State Health Plan-PPO premium increased 8.5%. Dental increased 10%. No changes in vision, life or ltd. No changes in deductibles or co-pays.

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2007-2008: State Health Plan-PPO premium increase 5%, Dental 15%. No change in vision, life or Ltd. HMO's premiums decreased 10%.

2008-2009: SHP premium did not increase. Employee's premium share increased from 5% to 10%. HMO's increased 4.5% and the employee's premium share increased to 5%. Prescription drug increased to $20.00 generic and $40.00 brand name, continued mandatory mail order for maintenance drugs (90 day supply) and mandatory generics. SHP deductible increase to $300.00 individual and $600.00 family in-network, out of network $600.00 individual and $1,200.00 family. Office visit co-pay increased from $10.00 to $15.00.

2009-2010: SHP premium increased 3% and HMO's increased 3-10% depending on area. No changes in Dental and Vision.

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95th Legislature Regular Session
Michigan Compiled Laws Complete Through PA 86 of 2009
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EXECUTIVE REORGANIZATION ORDER (EXCERPT)
E.R.O. No. 1996-5

38.1171 Transfer of responsibility for deferred compensation plans to state treasurer; transfer of suggestion awards program and other employee benefit programs from department of civil service to the department of management and budget.

WHEREAS, Article V, Section 2, of the Constitution of the State of Michigan of 1963 empowers the Governor to make changes in the organization of the Executive Branch or in the assignment of functions among its units which he considers necessary for efficient administration; and

WHEREAS, Article XI, Section 5, of the Constitution of the State of Michigan of 1963 vests in the Michigan Civil Service Commission, inter alia, plenary authority to fix rates of compensation for all classes of positions, to make rules and regulations covering all personnel transactions, and to regulate all conditions of employment in the state classified service; and

WHEREAS, the Civil Service Commission, as provided in Article XI, Section 5, of the Constitution of the State of Michigan of 1963, and in Act No. 306 of the Public Acts of 1976, being Section 38.1151 of the Michigan Compiled Laws, has authorized the Department of Civil Service to implement and administer (1) the State of Michigan Deferred Compensation Plan I under Section 457 of the Internal Revenue Code and (2) the Michigan State Employees Deferred Compensation Plan II under Section 401(k) of the Internal Revenue Service Code (collectively, the "Deferred Compensation Plans" or "Plans"); and

WHEREAS, through Act No. 96 of the Public Acts of 1996, which amends Act No. 306 to transfer the administration and investment of the Deferred Compensation Plans from the Department of Civil Service to the State Treasurer and which also withdraws as of October 1, 1996 all authority with respect to the Deferred Compensation Plans from the Department of Civil

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commissions, the principal executive officer of boards and commissions heading principal departments, employees of courts of record, employees of the legislature, employees of the state institutions of higher education, all persons in the armed forces of the state, eight exempt positions in the office of the governor, and within each principal department, when requested by the department head, two other exempt positions, one of which shall be policy-making. The civil service commission may exempt three additional positions of a policy-making nature within each principal department.

The civil service commission shall be non-salaried and shall consist of four persons, not more than two of whom shall be members of the same political party, appointed by the governor for terms of eight years, no two of which shall expire in the same year.

The administration of the commission's powers shall be vested in a state personnel director who shall be a member of the classified service and who shall be responsible to and selected by the commission after open competitive examination.

The commission shall classify all positions in the classified service according to their respective duties and responsibilities, fix rates of compensation for all classes of positions, approve or disapprove disbursements for all personal services, determine by competitive examination and performance exclusively on the basis of merit, efficiency and fitness the qualifications of all candidates for positions in the classified service, make rules and regulations covering all personnel transactions, and regulate all conditions of employment in the classified service.

State Police Troopers and Sergeants shall, through their elected representative designated by 50% of such troopers and sergeants, have the right to bargain collectively with their employer concerning conditions of their employment, compensation, hours, working conditions, retirement, pensions, and other aspects of employment except promotions which will be determined by competitive examination and performance on the basis of merit, efficiency and fitness; and they shall have the right 30 days after commencement of such bargaining to submit any unresolved disputes to binding arbitration for the resolution thereof the same as now provided by law for Public Police and Fire Departments.

No person shall be appointed to or promoted in the classified service who has not been certified by the commission as qualified for such appointment or promotion. No appointments, promotions, demotions or removals in the classified service shall be made for religious, racial or partisan considerations.

Increases in rates of compensation authorized by the commission may be effective only at the start of a fiscal year and shall require prior notice to the governor, who shall transmit such increases to the legislature as part of his budget. The legislature may, by a majority vote of the members elected to and serving in each house, waive the notice and permit increases in rates of compensation to be effective at a time other than the start of a fiscal year. Within 60 calendar days following such transmission, the legislature may, by a two-thirds vote of the members elected to and serving in each house, reject or reduce increases in rates of compensation authorized by the commission. Any reduction ordered by the legislature shall apply uniformly to all classes of employees affected by the increases and shall not adjust pay differentials already established by the civil service commission. The legislature may not reduce rates of compensation below those in effect at the time of the transmission of increases authorized by the commission.

The appointing authorities may create or abolish positions for reasons of administrative efficiency without the approval of the commission. Positions shall not be created nor abolished except for reasons of administrative efficiency. Any employee considering himself aggrieved by the abolition or creation of a position shall have a right of appeal to the commission through established grievance procedures.

The civil service commission shall recommend to the governor and to the legislature rates of compensation for all appointed positions within the executive department not a part of the classified service.

To enable the commission to exercise its powers, the legislature shall appropriate to the commission for the ensuing fiscal year a sum not less than one percent of the aggregate payroll of the classified service for the preceding fiscal year, as certified by the commission. Within six months after the conclusion of each fiscal year the commission shall return to the state treasury all moneys unexpended for that fiscal year.

TESTIMONY OF BRIT SATCHWELL, PRESIDENT OF THE ANN ARBOR EDUCATION ASSOCIATION, BEFORE THE HOUSE PUBLIC EMPLOYEE HEALTH CARE REFORM COMMITTEE, REP. PAM BYRNES, CHAIR.

SEPTEMBER 10, 2009

Madame Chairwoman, members of this committee, I thank you for the opportunity to speak here today on this critical issue. My name is Brit Satchwell, and I'm the president of the Ann Arbor Education Association, the AAEA, which represents the over 1,500 teachers, office professionals, and educational support personnel of the Ann Arbor Public Schools. But my title is really just a fancy way of saying that I am a 6th grade math teacher who speaks for my members with a teacher's voice. It is with that voice, and the voice of a father, that I offer my comments today.

The driving force behind the proposed legislation we are considering is known to all and has been for years. Our health care system has grown in complexity and cost to the point that we as a nation, a state, a community, and as individuals can no longer rely with confidence on the meaning that the words "health ***insurance***" imply. 48 million Americans go without, tens of millions are underinsured, and many who think they are adequately insured are tragically

proven wrong when the cost considerations that intercede between the doctor and the patient overrule that patient-centered relationship. The costs and inefficiencies of our health care system too often turn the word "insurance", in effect, into a lottery driven by cost considerations alone, thus defeating the very purpose that was intended to be the security provided by health insurance. When this happens, the lives and financial security of real people are devastated in the harshest terms imaginable.

To weigh the ***true*** cost of anything, consumers must consider not only the cost, but the value or benefit purchased at that cost… the "bang for the buck". Every coin has two sides. To focus on just one side of the coin is to be blind to the coin itself. Upon careful reading, this legislation makes no bones about its primary goal, to contain costs… it reads like a one-sided coin. So while I sincerely applaud its attempts to address the core failures of our health care system, I have questions about its ability to achieve its stated purpose. I'm here today to urge you to take an equal look at both the cost and benefit sides of the coin before moving this legislation forward. I worry that without closer scrutiny, this legislation, despite its best intentions, will turn the health ***insurance*** of over 500,000 Michiganders into health ***accountancy***, and in the process we'll excuse ourselves by saying the we did the best we could because cost considerations beyond our control trumped the health and financial security of

those half million families. We can and must do better. Indeed, every industrialized nation in the world does better.

But to this legislation in particular and the questions regarding its benefits that a thorough and balanced deliberation requires:

First and foremost of the questions I recommend to you is exactly what benefits will be provided? I read the bill with the eyes of a consumer and a father looking for insurance terms such as "vision care", "dental benefits", "disability coverage", and "major medical". The bill speaks in rather general terms about the structure of the proposed pool, its administration, its intentions, its attempts to control costs, but does not describe ***any*** benefits that go beyond the very fuzzy term "health". Before being forced from my current plan, for which I've chosen to contribute co-pays, deductibles and over $3,400 of premiums from my own pocket, I'd expect at the very least to be guaranteed what ***categories*** of benefits would be provided.

I also have extreme "buyer beware" hesitations regarding who will be in charge of determining these "sight unseen" benefits as the state wrestles with the ebb and flow of its budget. This legislation places the pool's regulatory board under the auspices of the Department of Management and Budget, but in the same

breath grants it complete autonomy from that department's oversight. To whom shall I look when I hear the march of accountants' feet, the latest budget projections in hand, approaching the health and financial security of my family? The board's members would be appointed and removed by the governor, an office that is nothing ***but*** subject to political and budgetary winds. Will the governor be responsible for ongoing oversight? Where in this legislation am I to find anything but the certainty that my insurance ***will*** shift with winds that are guaranteed to shift according to cost rather than benefit considerations? At what point does actual, predictable, reliable insurance come onstage? When I read this legislation, the insurance itself sounds like a "draft pick to be named later". Ladies and gentlemen, I place a higher priority on my family's health and security than that, and I know that the other half million families that could be subjected to the current vagaries of this legislation do as well.

I also wonder for whom the "clinical advocate" in section 12(e) advocates. Obviously not for the doctor or the patient. This advocate would provide a "second opinion" not requested by either party. Instead, the advocate would serve no discernible purpose other than to stand between patient and physician with a sieve to winnow out diagnoses and treatments that fail to pass cost criteria... the very sort of problem that plagues our current system... an emphasis on cost over health that nonetheless allows costs to soar.

The legislation provides "opt out" provisions under specific circumstances, but I ask that these provisions be reviewed with closer scrutiny by this committee. While imagining scenarios where these provisions might be invoked, I encountered a significant speed bump in the requirement for employers to pay for actuarial studies to substantiate their opt out request. In addition, I recommend more specificity regarding section 7(h), the ***single*** sentence that promises to develop methods to extend the ***option*** to participate in the pool to the private sector. As a public employee addressed by the rest of this legislation, I, too, would hope to be offered the courtesy of such an ***option*** to participate. I much prefer options to lesser coverage that is mandated.

Representative Byrnes, you were most gracious and helpful in arranging a conversation between Speaker Dillon and me a few weeks ago after he released his white paper on this issue. I am and will remain grateful to you for that opportunity. In that discussion, I asked Speaker Dillon exactly where the cost savings of his plan would be realized. To my mind - and as a lifelong learner I welcome any insights I may not have considered - common sense seems to dictate that they can only occur at either the state or school district level when teachers are the proposed targets.

To occur at the state level, foundation grants would have to be reduced. A recent statutory commission on government efficiency that addressed cost consolidation among public employees shared this conclusion. Were that to happen, funding to districts would, I assume, be cut in direct proportion to the cost savings imposed by this legislation. The ***net*** savings to the districts would, therefore, be essentially zero. On a relative basis, districts would still face the burdens of under funding they now bear… the same pain, but no gain.

To occur at the district level, foundation grants would have to ***not*** be cut. Speaker Dillon assured me, in candid terms I appreciated, that cuts were not his intention, but because he is the Speaker of the House and not the legislature itself, he could not guarantee this. But if foundation grants would not be cut, the question circles back to where are the savings? I do not pretend to speak for the Speaker, but his response centered on the savings afforded "system wide" via economies of scale, the efficiencies of purchasing drugs and services for a vast pool, through improvements in IT and wellness programs. While I am no expert and would welcome a much closer look at the cost assumptions behind this legislation and his response to me, I wonder if savings of $900 million that have been touted are a bit of a stretch. Indeed, experts much more capable than I have recently testified before this committee that this legislation is impossible to cost out because it contains no health plans to cost. More details,

please. But if $900 million ***is*** a realistic number, why are such efficiencies not being legislatively mandated upon the existing system, imperfect as it ought not to be? Could the state not force standardized protocols upon existing insurers, force them to purchase drugs and services from a centralized clearinghouse, impose mandates for best practices? This, after all, is where all efforts are now being focused at the national level, with or without their "public option." In asking these questions, I wonder why half a million citizens would have to be forced out of their current health plans into a common pool with undefined benefits and under oversight that is currently nowhere in sight while other means of containing health costs are headline news.

I want to close with a teacher's voice. I, and other teachers around the state, have for years been making choices at the bargaining table between wages and health coverage. Each district, with teachers at the table with administrators engaged in the epitome of appropriate adult problem solving that ***is*** collective bargaining, have collaboratively balanced their own compensation choices based on ***their*** needs. Neither side comes away fully satisfied; neither side comes away fully disappointed. This is exactly the result my mother recommended to my brothers and me when we were fighting and she had had enough of our squabbling. My mother introduced me to the concept behind collective bargaining... responsible problem solving through compromise. Ann

Arbor's teachers recently entered into a tentative agreement with our administration. During the course of those negotiations, I polled my members frequently to take their pulse. Time and again, when asked to make "Sophie's Choices" between wages and health benefits, they responded overwhelmingly: "protect my health benefits". As a result, Ann Arbor's teachers have now agreed to take the first wage freeze in our history. We see the financial landscape and we are stepping up to help our district and our programs. We have also agreed to increase our prescription co-pays. I want you to know that every member pays out of her or his ***own*** pockets to retain the health plan they choose. We are spending our own money and forgoing wages in order to exercise our choice within an imperfect yet free health care market as consumers. We have always agreed in collective bargaining to have our wages and benefits capped, a concept that would raise howls of outrage and derision if imposed upon the private sector. Given this, I cannot help but wonder why public employees, with teachers most prominent in that spotlight, have been singled out to bear the burden of a cure that doesn't hold much apparent promise of curing a problem not of their making... teachers are not the health care system, nor are we health care's problem. Were the state to propose a truly universal single payer plan for all Michiganders, my citizenship would trump my union membership in a heartbeat to serve that greater good. Until

then, I'll do everything I can to hold onto health care that is of a quality that should be the right of all.

I'll close by saying that as big as the issue is, as important it is, and as much as I appreciate your attention and time on this topic, I think this legislation deals with just one symptom among many faced by our state, and in doing so helps to kick the root problem down the road despite its best intentions. The root problem is that we have not yet figured out how to fund essential services under our current revenue structure. Until that is accomplished, we will revisit this and other topics deserving of adequate funding in a symptomatic manner. If the underlying problem is how to fund schools, I personally volunteer to be placed into a graduated income tax structure and to pay a wide, thin service tax to support the greater good that ***is*** the society I rely upon for my heath and opportunities.

I want to sincerely thank you for your time and for considering my comments. I'll answer any questions you might have to the best of my ability.